DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMF 07/20/	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIE D HOSPITAL NOR		215 W	ADDRESS, CITY, STATE, ZIP CO 4TH ST STE 200 WAKA, IN46544	ODE	
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S0000		or a standard licensure :: 002605 aly 18-20, 2011 CCSW or RN urse Surveyor	S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

002605

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		152018	B. WIN			07/20/2	011
					DDRESS, CITY, STATE, ZIP CODE		
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	O HOSPITAL NORT	HERN INDIANA		L	VAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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80318	410 IAC 15-1.4-1(C)(6)(F)					
S0318	for managing the has governing board so following: (6) Require that the officer develops por for the following: (F) Ensuring cardiaresuscitation (CPF accordance with cand hospital policy including contract provide direct patients assed on docume interview, the fact CPR competence. 1.) Hospital policy "For both patients who have the Hospital and Meaning CPR competer Resuscitation is considered."	board is responsible hospital. The hall do the e chief executive policies and programs opulmonary R) competence in urrent standards of practice of for all health care workers, and agency personnel, who ent care. ent review and staff collity failed to ensure e for 4 of 10 physicians. cy #MS-012, titled CPR, indicated the following: a safety and quality of 1 needs to assure those e a cardiac arrest have dical Staff members who ent Cardiac considered a Standard of following Medical Staff: ternal Medicine,	S0	318	KINDRED HOSPITAL NORTHERN INDIANAMishawaka, IndianaHospital License #011-002605-1Facility #002605INDIANA STATE DEPARTMENT OF HEALTHSTATEMENT OF DEFICIENCIES AND PLAN (CORRECTIONAugust 2011 S318: Completion DateCorrection of Deficience August 1, 2011The Medical (CPR Competency Policy was revised; this included an upd of Licensed Independent Practitioner (LIP) based on the specialty. The revised policy states "Cardiac Resuscitation applied and a Standard of Decision of the special states and the special states are special states.	Staff s ate neir now n is	10/14/2011
	1 0	vascular/Thoracic			considered a Standard of Pra for the following Medical Stat		
	_	PhysiciansNight			Hospitalist (0700 – 1900		
	Coverage."	J 2.41.00 1 1.1 5 110			attending/admitting physiciar		
	20. 01480 .				daily in-house) House Phys		
	2.) On 7-19-11 a	at 12:45pm, upon			 Resident – Night Coverage Only (1900 – 0700 daily in-ho 		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		152018	B. WIN	G		07/20/2011
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				215 W 4	4TH ST STE 200	
KINDREI	D HOSPITAL NORT	HERN INDIANA		MISHAV	WAKA, IN46544	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	document review	, and in the presence of			for emergent situations)."	
	Employee A2, it	was noted that 4 of 10			September 7, 2011The CPR	
	physicians were	lacking documentation of			Competency Policy will be approved at the Medical	
	CPR competency	7.			Executive/Credentials Comm	nittee
	1 3				on September 7, 2011.	
	3) On 7-19-11 a	t 3:45pm per interview			Attachment 1	
	· ·	11, it was verified that			September 7, 2011The Medi	
					Executive/Credentials Comm	l l
	there was no CPI				will discuss and determine th	ie
	available for revi	ew.			dates in which Licensed	
					Independent Practitioners, policy, will be required to have	
				their CPR competency	^{'C}	
				up-to-date. Attachment 2The	.	
					proposed time frame will be	
					follows: Review As of August	: 31,
					2011, 100% of night covera	ge
					physicians have current AC	CLS;
					7 out of 10 Hospitalists	
					scheduled have current	
					ACLS. Changes Current ACLS	5
					September 1, 2011 Effective September 1, 2011, per the	
					policy, any Hospitalist or Hou	
					Physician – Resident-Night	
					Coverage Only requesting in	itial
					appointment or reappointme	
					must provide proof of curren	
					ACLS certification. Individual	l l
					with certification expiring dur the processing of the applica	· 1
					will be granted conditional	
					privileges with the understan	ding
					that certification will be renev	· I
					within 1 month after condition	nal
					appointment.	_
					October 14, 2011The remain	- 1
					3 LIPs are scheduled to atte	l l
					ACLS review class on Octob 13.	ei

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	Corrective Action/Monitor August 1, 2011The Medical Coordinator has notified all L without a CPR competency of update their compliance. September 1, 2011Currently out of 10 Hospitalists have current ACLS competency. September 7, 20113 out of 1 Hospitalists will be notified b letter from the Medical Executive/Credentials Comm of the date CPR certification due and determination of privileges if the physician rer out of compliance. August 1, 2011 and ongoine Medical Staff Coordinator wi review all new applications for Hospitalist and House Physi Resident-Night Coverage to ensure the physician has AC certification. If ACLS is not current, physician will be not of the certification requireme and application will be place hold until proof of certification been received by the Medical Staff Office. August 1, 2011 and ongoine Medical Staff coordinate maintains a list of LIPs curre	ring Staff I.IPs to to to ting Staff I.IPs to
				ACLS status and will notify the LIP in writing 60 days prior to expiration. If certification is not according to the control of the control o	
				maintained by the LIP within	• • • • • • • • • • • • • • • • • • •
				days of expiration, it will be	·
				referred to the Medical Direc	tor
				for follow-up.	
				□Responsible Persons	
				□Jackie Nadolny, Medical S	taff
				CoordinatorSuzanne Morgar	

SOURCE S	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA (NA) ID SUMMARY STATEMENT OF DEPLICIENCES TAG SUMMARY STATEMENT OF DEPLICIENCES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SO322 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and procedures that are updated as needed and reviewed at least triennially. Based on document review, the facility failed to ensure the Burlodge Tray Delivery System Policy was updated to meet the state requirements for hot and cold holding, 410 IAC 7-24-187. Findings included: 1. Triumph Our Lady of Peace Hospital Burlodge Tray Delivery System Policy last reviewed January 2011 stated, "Acceptable standards for hot food ois 130 degrees Fahrenheit and cold foods will be below 50 degrees F for fruit and deserts and below 41 degrees F for fruit and deserts and below 41 degrees F for fruit and cold beverages." The policy noted the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
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De maintained at 153 degrees r of		Findings included 1. Triumph Our Burlodge Tray D last reviewed Jan "Acceptable standagrees Fahrenhe below 50 degrees and below 41 deg	d: Lady of Peace Hospital elivery System Policy uary 2011 stated, dards for hot food is 130 eit and cold foods will be s F for fruit and deserts grees F for milk/dairy and			OF HEALTH STATEMENT OF DEFICIENCIES AND PLA CORRECTION August 2011 S322 Correction of Deficiency Burlodge Tray Delivery System (BTDS) Policy and Procedure w updated/revised to include (see Attachment 3): Ø Test tray temperature of hot	AN OF	
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	doing periodic to	est trays and to log it on			41 degrees F or below.	
	the Temperature	and Scoring Guide. The			Ø The contracted service, Sair	
	Temperature and	Scoring Guide requires			Joseph Regional Medical Cente (SJRMC):	r
	1 -	erved above 120 degrees F			a) recording and logging tr	POV.
		and cold food to be			line temperature;	ay
		55 degrees F to be			b) downloading ambient	
		ards. The policy and			temperatures on a weekly basis;	,
		1 7			c) tray line temperatures ar	
	Scoring Guide la	-			recorded and logged by the diet	ician
	acceptable stand	ards.			on a weekly basis.	
					Completion date August 13, 20	11
	2. Retail Food F	Establishment Sanitation				
	Requirements 410 IAC 7-24-187,				The BTDS policy and procedur	e
	Potentially Hazard	dous Food; Hot and Cold			includes that test trays will be performed at Kindred Hospital	
	Holding, states, "	Potentially hazardous			Northern Indiana by the dieticia	un or
	food shall be ma	intained as follows: At			designee to ensure that hot food	
	one hundred thir	ty-five (135) degrees			135 degrees F or above and that	I
		ove, and at forty-one (41)			food is at 41 degrees F or below	
	degrees Fahrenh	-			Hot foods less than 135 degrees	will
	degrees rameim	en or less.			be reheated to 165 degrees and	
					maintained for 15 seconds. Col	d
					foods will be replaced.	
					Completion date August 13, 20)11
					A meeting was held on August	19.
					2011 with the Director and Mar	
					of the contracted service and Ki	·
					Hospital Northern Indiana to re-	view
					the Burlodge Tray Delivery Sys	
					Policy and Procedure, and discu	ISS
					any issues related to the food	
					delivery.	
					Meetings will continue as neede	ed to
					increase communication and ini	
					problem solving.	
					Completion date August 19, 20)11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE S COMPLI 07/20/20	ETED
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Review During the meeting with the contracted service, the enterior from tray line set-up to dethe patient was reviewed. Completed August 18, 20 The Burlodge Tray Delive Policy and Procedure was and updated to include ten required for hot/cold foods responsibility of taking reand interventions if the terdo not meet the standards in the policy. Completed August 18, 20 Changes Ø Reviewed roles of conservices for monitoring of temperature. Ø Reviewed role of dietidesignee for monitoring of temperature. Ø Instituted a log for the temperature log (Attachmed August 18, 2011 Corrective Action/Monite Weekly download logs of are to be submitted to the from the contract service of (Example 1). August 18, 2011 Ongoing The temperature of hot and meals will be taken once a meal seven days a week to meal seven days a week	he ire process livery to 11 rry System reviewed inperature is and cording, inperatures identified 11 tracted cian or f daily ent 4) pring the BTDS dietician weekly d cold iday per	DATE
				temperatures per the polic procedure and appropriate taken.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE COMPL	
AND TEAN	or connection	152018	A. BUIL			07/20/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				4TH ST STE 200		
KINDREI	O HOSPITAL NORT	HERN INDIANA		MISHAV	NAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFY TING INFORMATION)		IAG	August 18, 2011 Ongoing		DAIL
					TTI C.d.		
					The summary of the temperatur will be reviewed by the dietician	-	
					weekly.		
					August 18, 2011 Ongoing		
					On a monthly basis the dietician	n will	
					report to the Chief Clinical Offi		
					the reports with documented act items or follow-up taken.	tion	
					September 1, 2011		
					The Reports will be submitted		
					quarterly to the Clinical Quality	,	
					Council. The reports will be a		
					standing agenda item beginning		
					the next meeting on November 2011. The report will include d		
					from August 1 until October 31		
					2011. November 1, 2011		
					1, 2011		
					Responsible Person(s)	1	
					Jane Mason, RN, MS, Chief Cli Officer	inicai	
					Dawna Summers, RhD, Dieticia	an	

AND PLAN OF CORRECTION IDENTIFICA 152018 NAME OF PROVIDER OR SUPPLIER		JILDING NG	00	COMPLE	
				1 07/00/00	
NAME OF PROVIDER OR SUPPLIER	B. W1	B. WING		07/20/20)11
NAME OF PROVIDER OR SUPPLIER		STREET AT	DDRESS, CITY, STATE, ZIP CODE		
			TH ST STE 200		
KINDRED HOSPITAL NORTHERN INC	DIANA	1	VAKA, IN46544		
(X4) ID SUMMARY STATEMENT (OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE	PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	- I	COMPLETION
TAG REGULATORY OR LSC IDENTIF	FYING INFORMATION)	TAG	DEFICIENCY)		DATE
S0330 410 IAC 15-1.4-1(c)(6)(K)				Ī	
(c) The governing board is refor managing the hospital. T governing board shall do the following: (6) Require that the chief exe officer develops policies and for the following: (K) Maintaining personnel reeach employee of the hospitinclude personal data, educatexperience, evidence of part in job related educational act and records of employees who post offer and subsequent examinations, immunizations tuberculin tests or chest x-rate applicable. Based on personnel file resinterview, the facility failed testing/screening was performed according to policy for 14 members (R1- 14). Findings included: 1. Review of personnel file evidenced the following: A. The last TB testing for R1, R2, R3, R4, R5, R8, R R12, and R13 was perform of 2009. B. The last TB testing for R6 was performed 01/05/1	ecutive programs cords for all which stion and icipation ivities, nich relate t physical s, and y, as view and d to ensure TB formed of 14 staff es on 07/19/11 staff members 9, R10, R11, and in October staff member	0330	KINDRED HOSPITAL NORTHERN INDIAN Mishawaka, Indiana Hospital License #011-002 Facility #002605 INDIANA STATE DEPART OF HEALTH STATEMENT OF DEFICIE AND PLAN OF CORRECT August 2011 A330: Completion Date Correction of Deficiency Completed July 1, 2011 The Tuberculosis Screening Associates Policy and Procewas revised and updated to indicate the screening of employees. Completed July 1, 2011 The Tuberculosis Screening Questionnaire was updated,	A 2605-1 MENT NCIES STION of dure	09/15/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M5JM11 Facility ID:

002605

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	R/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		152018	B. WIN			07/20/2011
		1	P		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIEI	₹			4TH ST STE 200	
KINDRE	D HOSPITAL NORT	THERN INDIANA		1	NAKA, IN46544	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	C. The last TB t	testing for staff member			reviewed to correlate with the	9
	R7 was perform	ed 03/24/10.			Policy and Procedure.	
	D. No TB testin	g/screening was provided			Review	
	for staff member	r R14.			Completed August 10, 2011	
					The Policy/Procedure and	
	2. At 12:15 PM	on 07/19/11, staff			Screening Assessment were	
		cated the facility was			approved by the Infection	
		l by the CDC that they			Prevention/Antibiotic Commi	.
		sk county and would no			on August 10, 2011 (Attachm 5, 6, 7).	ICHIO
		erform the actual TB			Completed August 16, 2011	
		He/she provided the			The Policy/Procedure and	
		_			Screening Assessment were	
		rding Tuberculosis			approved at the Clinical Qua	lity
	1	June 2011, and a			Council on August 16, 2011 (Attachment 8).	
	•	uly 2011. Documentation				
		al of this policy could not			Changes	
	_	owever, this new policy			Completed August 17-26, 2	011
	still stated, "1.	A documented TB risk			Employee mandatory staff	
	assessment will	be reviewed annually as			meetings held August 17-26	,
	part of the TB E	xposure Control plan and			2011 to review the Policy/Procedure and Screen	ning
	TB surveillance	will be monitored on an			Assessment.	iiig
	ongoing basis; a	s a function of the			September 15, 2011	
	Infection preven	tion Program."			All employees are required to	o
					return their Tuberculosis	
	3. The policy in	effect last fall,			Screening to their Director by	y
	1 .	creening of Employees",			August 31, 2011.	
	1	05, stated, "To minimize			Corrective Action/Monitoring	ng
	_	of tuberculosis (TB) by			September 1-15, 2011	-
		nteers and contract			> As of 8/31/11, 85% of the	
	1	integral part of the			employees completed their T	В
	[facility name] c				Screening Assessment. The Chief Clinical Officer i	o to
	1	-			 The Chief Clinical Officer in notify all employees with 	5 10
		ntrol Plan, all employees,			outstanding assessments the	at if it
	1	ontract personnel will			is not completed and returne	
	1	screening for TB infection			9/15/11, they will be suspend	
	and disease in th	e month of February."			from working.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152018		(X2) MULT A. BUILDII		STRUCTION 00	(X3) DATE S COMPL	ETED	
NAME OF D	PROVIDER OR SUPPLIER		B. WING S	TREET AD	DDRESS, CITY, STATE, ZIP CODE	07/20/20	J
	D HOSPITAL NORT				TH ST STE 200 /AKA, IN46544		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	members A1 and annual TB screer last year and it w				Completed August 16, 2011 The Infection Preventionist had responsibility to initiate the TE Screening Assessment annual beginning October 2012. Responsible Person(s) Diana Korpal, Infection Preventionist Jane Mason, Chief Clinical Of Suzanne Morgan, RN, MS, Director, Quality Management	B ally,	
S0408	improvement prog of the hospital part program shall be owritten plan of improvements, but is n following: (2) All functions, in limited to the following (A) Discharge pla (B) Infection contr (C) Medication the (D) Response to experience of defined in 410 15-1.5-5(b)(3) Based on documents.	nall have an d, hospital-wide, ality assessment and ram in which all areas ticipate. The ongoing and have a lementation that ot limited to, the acluding but not ving: nning. col. erapy. emergencies as IAC	S040	8	KINDRED HOSPITAL NORTHERN INDIAN.	Α	08/18/2011
	services as a part	of its comprehensive nt and improvement			Mishawaka, Indiana Hospital License #011-002 Facility #002605 INDIANA STATE DEPARTI OF HEALTH	2605-1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		152018	B. WING		07/20/2011	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		215 W	4TH ST STE 200		
KINDRFI	O HOSPITAL NORT	HERN INDIANA	l l	AWAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX		CY MUST BE PERCEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	.	DATE	
				STATEMENT OF DEFICIE	l l	
	1.) Document re	view failed to show any		AND PLAN OF CORREC	SHON	
	information as to	monitor, standard and		August 2011		
		ation related to dietary		S409: Completion Date		
		anon related to dietary		S408: Completion Date Correction of Deficiency		
	services.			Completed August 1, 2011		
				The Dietary Services were r	not	
	2.) Interview with	th Employee A8 indicated		integrated into the Quality		
	that dietary servi	ces are not currently		Assessment and Improvement	ent	
	included in quali	ty review.		Program. The Dietician, Chi		
	1			Clinical Officer (CCO), and		
				Director of Quality Managen	nent	
				have reviewed and impleme	nted	
				criteria for reporting quality		
				assessment monitors from t	he	
				Dietary Department.		
				Review / Changes		
				August 18, 2011		
				The Contract Service Direct	_ ·	
				Manager, and Dietician met review the criteria and patie		
				satisfaction surveys.		
				Corrective Action/Monitori	na	
				August 18, 2011 Ongoing	"	
				Criteria was established for		
				monitoring and collection of	data	
				as follows:		
				➤ Daily temperature logs for		
				Burlodge Trays on a weekly		
				basis, to be submitted from	the	
				contract service to dietician		
				(Example 2).		
				➤ Dietician or designee to	,	
				monitor test tray daily hot ar cold foods (Example 3).	iu	
				➤ Patient Satisfaction Surve	ev to	
				be reviewed monthly by the	,,	
				dietician and contract service	es.	
				The survey question on a so		
				1 5 9 44 55 16 17 47 66		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/20/2011		
	PROVIDER OR SUPPLIER D HOSPITAL NORT		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE		
				1-5, 1 = never, 5 = All the ti you received meals during hospitalization, did you find food adequate?" September 1, 2011 Ongoin The quality monitoring repo be submitted monthly by the dietician (beginning monitor August 1), submitted for revith an action plan to the C September 1, 2011. The quite monitoring will be a standin agenda item under clinical services beginning with the Clinical Quality Council meron November 15, 2011 (Exal). Responsible Person(s) Jane Mason, Chief Clinical Suzanne Morgan, RN, MS, Director, Quality Managemed Dawna Summers, RD, Diet	your the Ig Irts will e Irs Iris will e Irs Iris W Iris W Iris W Iris W Iris W Iris W Iris W Iris W Iris W Iris W Iri		

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFCINCY MIST BE PERCEDED BY PULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (A) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refirigerators. (CC) Refrigerator and freezer temperature monitoring, based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food STREETADRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544 DPROVINCES, ALDERICA, INCREDENCY, INC	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG (PACT DEFICINCY MIST BE PERCEDED BY FULL TAG (PACT DEFICINCY MIST BE PERCEDED BY FULL TAG (I) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control control. These include, but are not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (BB) Medications in nutrition refrigerators of patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food STREET ADDRESS, CITY, STATE, ZIPCODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544 MISHAWAKA, IN46544 ID PREFIX TAG PREFIX			152018	1			07/20/2	011
Sumary Statement of Depticies of Mishawaka, Indesdation of the Mishawaka, Indiana Hospital toensure the refrigerators.				D. WINC		DDRESS CITY STATE ZIPCODE		
KINDRED HOSPITAL NORTHERN INDIANA IXA-IID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG SO610 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee to responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control committee to monitor and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (CC) Refrigerator and freezer temperature monitoring to ensure food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food MISHAWAKA, IN46544 IID PREFIX PREFIX PREFIX TAG IID PREFI	NAME OF P	ROVIDER OR SUPPLIER	L					
PREFIX TAG RECLATORY OR ISC IDENTIFYING INFORMATION) AND INFORMATION OR ISC IDENTIFYING INFORMATIONS TAG RECLATORY OR ISC IDENTIFYING INFORMATIONS TAG RECORDS REFERENCED THE APPROPRIATE ONLY OR ISC IDENTIFYING INFORMATIONS) (f) The hospital shall establish an infection control committee to monitor and guide the infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food	KINDRED	HOSPITAL NORT	HERN INDIANA					
TAG REGILATORY OR LSC IDENTIFYING INFORMATION) S0610 410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control committee responsibilities shall infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
S0610 410 IAC 15-1.5-2(f)(3)(D)(X) (f) The hospital shall establish an infection control committee to monitor and guide the infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control control. These include, but and similarly is not limited to, the following: (X) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		-E	COMPLETION
(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (X) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food infection control. KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011	S0610	410 IAC 15-1.5-2(1	f)(3)(D)(x)					
it regards to hot/cold hold of food being Correction of Deficiency		infection control co and guide the infer program in the face (3) The infection corresponsibilities shan not be limited to, the (D) Reviewing and in procedures, politication of the control. These incollimited to, the following and storage for all in food handling with in food handling with in food handling with in the control. (AA) Storage of empatient refrigerators. (CC) Refrigerators in the refrigerators and interview, the the refrigerators in the required temperature density and interview the required temperature density and required by 410 In Establishment Sa	committee to monitor ction control cility as follows: control committee all include, but the following: different recommending changes icies, and programs at to infection clude, but are not owing: food preparation personnel involved which includes, but the following: mployee food in res. in nutrition and freezer toring. ation, document review the facility failed to ensure for patient food on the 2 didaily temperature sure food was stored at peratures and failed to handling practices as IAC 7-34 Retail Food anitation Requirements as	Soci	610	NORTHERN INDIAN Mishawaka, Indiana Hospital License #011-002 Facility #002605 INDIANA STATE DEPART OF HEALTH STATEMENT OF DEFICIEL AND PLAN OF CORREC August 2011 A610: Completion Date Correction of Deficiency	A 2605-1 MENT NCIES	09/01/2011
served to the patients. Completed August 1, 2011 The two nursing units did not		-	_				not	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M5JM11 Facility ID:

002605

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPI	LETED
		152018	1	LDING		07/20/2	011
		102010	B. WIN			0172072	.011
NAME OF I	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	no vibbit on our burn			215 W 4	4TH ST STE 200		
KINDRE	D HOSPITAL NORT	THERN INDIANA		MISHAWAKA, IN46544			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					have daily temperature		
Findings included:				monitoring to ensure patient	food		
					was stored at the required		
	1. During the tour	of the Med/Surg unit,			temperatures. The temperat	ures	
	beginning at 2:30 P	_			were not recorded.		
		aff members A7 and A8, the			➤ The "Food Safety –		
		food refrigerator were			Preparation, Handling, and		
		ome daily temperature			Storage Policy / Procedure"	was	
	documentation.				revised (Attachment 9).		
	2 During the tour			<u>Review</u>			
	2. During the tour of the High Observation unit, beginning at 3:15 PM on 07/19/11 and				Completed July 21, 2011		
		off members A7 and A8, the			The staff was educated on:		
		food refrigerator were			a) Maintaining the daily		
		ome daily temperature			temperature logs for all		
	documentation.	ome daily temperature			refrigerators and freezer in t	he	
	documentation.				nourishment room.		
	2 44 9,45 4 14	07/20/11			b) Instructions to follow if		
		07/20/11, staff member A7			temperatures were not met.		
		erator temperature monitoring			c) The Clerical Coordinators	will	
	logs for the last 6 m	ionths.			be responsible for the daily		
					recording in the log and		
		gs of the patient food			intervention if the temperatu	res	
		Med/Surg unit evidenced the			do not meet the standard.		
	following:				d) The dietician will be		
					responsible for daily		
		6 out of 31 days in January			communication with the Cle	rical	
	2011.				Coordinators to monitor		
		1 out of 28 days in February			completion of logs and		
	2011.				interventions.		
		out of 31 days in March 2011.			Completed August 1, 2011		
		out of 30 days in April 2011.			A new digital thermometer w	/as	
		out of 31 days in May 2011.			purchased for accurate		
	F. No checks for 3	out of 30 days in June 2011.			temperature readings.		
					*See A322 response for		
		ogs of the patient food			additional information		
	_	High Observation unit					
	evidenced the follo	wing:			<u>Changes</u>		
					Completed September 1, 2		
	A. No checks for 7	out of 31 days in January			The "Refrigerator Temperator		
	2011.				Log" was revised (Attachme	nt 9).	
	i		1				ı

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	152018	A. BUI	LDING	00	07/20/20	
		152016	B. WIN			07720720	711
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
KINDREI	D HOSPITAL NORT	HERN INDIANA		1	4TH ST STE 200 NAKA, IN46544		
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	B. No checks for 2	2 out of 28 days in February	İ		Corrective Action/Monitorin	<u>ng</u>	
	2011.				September 1, 2011 Ongoing		
		out of 31 days in March 2011.			The quality monitoring report		
		out of 30 days in April 2011.			be submitted monthly by the dietician (beginning new mor		
		0 out of 31 days in May 2011. 3 out of 30 days in June 2011.			September 1, 2011). Submit		
	1. The checks for it	out of 50 days in valic 2011.			for review with an action plan		
		07/20/11, staff member A4			the Chief Clinical Officer on		
		eets stated a daily check was to			October 1, 2011. The quality		
	· ·	vas no policy outlining the			monitoring will be a standing agenda item under clinical		
	procedure or respon	isible staff member.			services beginning with the r	next	
	7 The hot food	received on 7/18/2011			Clinical Quality Council meet		
		es at 129 F, grilled			on November 15, 2011 (Exa	mple	
	1	t 129.5 degrees F,			5) .		
		i at 131 degrees F, and			Responsible Person(s)		
		•					
		#44 F. The temperatures #D1's dial thermometer.			Jane Mason, Chief Clinical C	Officer	
					Suzanne Morgan, RN, MS,		
		ter was calibrated to 42			Director, Quality Management Dawna Summers, RD, Dietic		
	1 -	makes the food actual			9/7/2011	,iaii	
	1 ^	legrees lower then the					
	· ·	The food temperatures					
		the Burlodge hot/cold					
	nolding equipme	ent for 10 minutes.					
	8. The Food Ter	nperature and Scoring					
		iewed for July, June and					
		n 6/6/11, the chicken					
	l *	ed potatoes and steamed					
		rved to the patients at					
		0 degrees Fahrenheit					
		lk was served at 50					
	degrees Fahrenheit. On 6/3/2011, the 2% milk temperatures were 64 degrees						
		temperature logs of the					
		-					
	i 1000 mat was be	ing served to the patients	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER D HOSPITAL NORT		B. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE TH ST STE 200 WAKA, IN46544	1 ***-	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	9. At 12:30 PM indicated the term not be taken until through a 20 min tray system. The the hot food while cooled. The nurst temperatures of the should be at the premoved from the indicated the term not taken on every randomly. #D1 is served to patient. Fahrenheit or aborder at 50 degree 10. Retail Food Requirements 41 Specifications for of Food states, "I hazardous food is of forty-one (41) below when received hot shall one hundred thirm received hot shall one hundred thirm.	ove and cold food to be rees Fahrenheit or below. Establishment Sanitation					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152018		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/20/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above, and at forty-one (41)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
S0932	one hundred thirty-five (135) degrees Fahrenheit or above, and at forty-one (41) degrees Fahrenheit or less." 410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.		S0932	KINDRED HOSPITAL NORTHERN INDIANAMishawaka, IndianaHospital License #011-002605-1Facility #002605INDIANA STATE DEPARTMENT OF HEALTHSTATEMENT OF DEFICIENCIES AND PLAN CORRECTIONAugust 2011 S932: Completion	09/15/2011		
				DateCorrection of Deficien Completed August 15, 201 Nursing Care Plans, the "Interdisciplinary Team Conference and Plan of Car were reviewed with no chan updates. Review August 11-30,	1 re"		

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Event ID:

M5JM11

Facility ID:

002605

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CON	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		152018	B. WIN			07/20/2011
NAME OF I	DROLUDED OD GUDDI IED		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			215 W 4	TH ST STE 200	
KINDREI	D HOSPITAL NORT	HERN INDIANA		MISHAV	VAKA, IN46544	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	2. The medical r	ecord for patient N3			2011Interdisciplinary Team	
	evidenced an admission date of 03/31/11,				Conference and Plan of Care	•
	but no initiation of a nursing plan of care				Policy and Procedure were	
	until 04/05/11.				reviewed with every admittin	g
	unui 04/03/11.				nurse. Expectations that the nursing care plan be initiated	l by
	2 The medical m	and for maticut NIA			the admitting nurse (Attachm	
		ecord for patient N4			10).	
l		nission date of 03/29/11,			September 1-14, 2011Rema	inder
		of a nursing plan of care			of admitting nurses to be	
	until 03/31/11.				educated on policy / procedu	ıre
					and expectations.	
	4. The medical r	ecord for patient N6			Changes	-i
	evidenced an adn	nission date of 03/19/11,			August 15 OngoingThe Nur Supervisor will concurrently	sing
		of a nursing plan of care			review all new admissions fo	r
	until 03/21/11.	8 F-1112 C-1 C-1112			initiation of a Plan of Care by	
	unui 03/21/11.				admitting R.N. The Nursing	
	5 The medical m	and for maticut NIIO			Supervisor will mentor the	
		ecord for patient N10			admitting nurse immediately	if
		nission date of 04/22/11,			Plan of Care is not initiated.	.
		of a nursing plan of care			Corrective Action/Monitor	
	until 04/25/11.				August 15, 2011 Ongoing Do August 2011, 66% Plans of 0	- 1
					initiated at admission.	Jaile
	6. The medical r	ecord for patient N12			September 1, 2011 Ongoing	ıø
	evidenced an adn	mission date of 05/24/11,			Daily admissions will be review	
		of a nursing plan of care			concurrently and the initiation	n of
l	until 05/25/11.	Or >= ******			the Plan of Care by the Nurs	
					Supervisor.Ø The Chief Clini	
	7 The modical r	record for nations M12			Officer (CCO) will counsel ea	
l		ecord for patient N13			admitting nurse that did not rethe expectation. Ø The CCO	
l		mission date of 06/17/11,			submit monthly reports to the	
		of a nursing plan of care			Director, Quality Managemen	
l	until 06/20/11.				(DQM) of the compliance	
l					percentage of "Plan of Care	
l	8. The medical record for patient N15				initiated at admission."Ø The	
l	evidenced an adn	nission date of 04/28/11,			percentage of compliance wi	
l		of a nursing plan of care			a standing agenda item unde clinical services beginning w	
until 04/29/11.				the next Clinical Quality Cou		
EORM CMS 3	2567(02-99) Previous Version	ns Obsolete Event ID:	 M5JM11	Facility II		•

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152018		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/20/2011		
	PROVIDER OR SUPPLIER D HOSPITAL NORT		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE 1TH ST STE 200 NAKA, IN46544		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
S0952	members A3 and				meeting on November 15, 20 □ Responsible Person(s) □ Jane Mason, Chief Clinical OfficerSuzanne Morgan, RN Director, Quality Managemen	, MS,	
	medications shall accordance with s medical staff policilis the blood transfuintravenous medical	tate law and approved es and procedures. usions and ations are ersonnel other than rsonnel shall have these procedures					
	review, and interensure staff folloblood administra reviewed of patie blood transfusior N5). Findings included 1. The facility per Blood Product A reviewed in June " E. Vital signs	blicy, titled "Blood and dministration", last 2010, stated on page 2. s (TPR & BP) are to be	S09	952	KINDRED HOSPITAL NORTHERN INDIAN Mishawaka, Indiana Hospital License #011-002 Facility #002605 INDIANA STATE DEPART OF HEALTH STATEMENT OF DEFICIE AND PLAN OF CORREC August 2011 S952: Completion Date Correction of Deficiency Completed August 1, 2011 The "Blood and Blood product Administration Policy and Procedure" stated vital signs (TPR & BP) are to be taken a	A 2605-1 MENT NCIES TION ct	09/28/2011
	taken and recorder prior to initiation	ed within 60 minutes of each unit of			recorded within 60 minutes of initiation, Fifteen minutes afte start of each unit, and at the		

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		152018	B. WING		07/20/2011
NAME OF I	PROVIDER OR SUPPLIER		STREI	ET ADDRESS, CITY, STATE, ZIP CODE	
				W 4TH ST STE 200	
KINDREI	D HOSPITAL NORT	HERN INDIANA	MISH	HAWAKA, IN46544	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	blood/blood prod	luct, 15 minutes after		completion. The transfusion	.
	start of each unit	, and at completion of		was to remain with the pati at least five minutes after the	
	each unit. F. Th	e transfusionist is to		of the unit.	ie start
	remain with patie	ent for a minimum of 5			
	minutes (15 prefe	erred) after initiation of		Review	
	transfusion and o	bserve for any		Completed August 1, 2011	
		of reaction or patient		Documentation between th	l l
	distress."	r r		electronic medical record a blood bank records were no	
	41501 455.			consistent:	JI
	2 The medical r	record for nationt N1		Vital signs pre-transfusio	n
	2. The medical record for patient N1 evidenced a unit of blood started at 1055			Vital signs 15 minutes aft	
				of transfusion	
		the pretransfusion vital		Vital signs post-transfusion	on
	• ` ′	mented at 1055 and the 15		(Example 11)	
		20. (The facility uses		<u>Changes</u>	
	1	ording.) A second unit of		Completed August 1, 2011	1
		1 at 1430 on 06/06/11 and		The Blood and Blood Produ	
	the pretransfusion	n VS were documented at		Administration Policy and	
		minute VS at 1515. The		Procedure was reviewed w	ith no
	record failed to s	how documentation of		changes made. Completed August 15, 20	14
	the transfusionist	remaining with the		The South Bend Medical	
	patient for the fir	st 5 minutes.		Foundation Director (Labor	atory
				Contract Services), Chief C	I
	3. The medical r	record for patient N3		Officer and Director Quality	
		of blood started at 1458		Management met to review	
		the pretransfusion vital		administration process. The process was determined to	
		nented at 1444 and the 15		the standards outlined in th	I
	• ` ′	58, the time of the		policy and procedure.	
		The record failed to		Completed August 16, 20	
		tion of the transfusionist		The Blood and Blood Produ	uct
				Administration Policy and Procedure was reviewed a	nd
	ı	he patient for the first 5		approved by the Clinical Qu	
	minutes.			Council on August 16, 201	
	l			(annual review) (Attachmen	
		record for patient N4			
	lacked document	ation on the transfusion		Corrective Action/Monitor	<u>ing</u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPLETED	
		152018	A. BUII B. WIN			07/20/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			TH ST STE 200		
KINIDDE	D HOSPITAL NORT	HEDNINDIANA			NAKA, IN46544		
KINDKE		HERN INDIANA		IVIIOTIAV	WARA, IN40544		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	LETION
TAG	!	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DA	TE
		time for a unit of blood			September 7 - 28, 2011	.	
	on 04/19/11. Th	e electronic medical			Education Program for (annu	' I	
	record indicated	documentation of			blood administration to all RI and LPNs to be reviewed:	18	
	pretransfusion VS at 1610, a transfusion start time of 1600, and VS on an				a) Vital signs pre-during and	nost	
					transfusion		
		assessment sheet at 1600 and 1630. A			b) informed consent		
		lood on the same date had			c) staying with patient at star	t of	
					transfusion	.	
		of a start time of 1835,			d) documentation on Blood E		
	1 ^	S at 1835, and 15 minute			forms and electronic medical record.		
		e record failed to show			September 1, 2011 Ongoing		
	documentation of	of the transfusionist			Concurrent monitoring of 100		
	remaining with the patient for the first 5				blood transfusions for	, , , ,	
	minutes.				documentation criteria. The	cco	
					will individually counsel the F	Ns	
	5 The medical	record for patient N5			and LPNs who do not meet t	ne	
		of blood started at 2145			standards.		
					September 1, 2011 Ongoing		
		the pretransfusion vital			The quality monitoring report		
	1	mented at 2145 and the 15			be submitted with an action p by the CCO monthly for the	oian	
	minute VS at 22	05. The post transfusion			standing agenda item under		
	BP was partially	written over the 15			clinical services beginning w	th	
	minute BP, maki	ing both BPs illegible. A			the next Clinical Quality Cou		
		lood was started at 0040			meeting on November 15, 20		
		the pretransfusion VS					
		d at 0040 and the 15			Responsible Person(s)		
		58. The record failed to					
					Jane Mason, Chief Clinical C	micer	
		ation of the transfusionist			Suzanne Morgan, RN, MS, Director, Quality Manageme	,,	
	_	he patient for the first 5				"	
	minutes.						
	6. At 11:00 AM	on 07/20/11, staff					
		A4 confirmed the record					
		indicated there was no					
	way it could be						
	1 -						
	i transfusionist rei	mained with the patient					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		152018	B. WING			07/20/2	011
KINDREI	PROVIDER OR SUPPLIER D HOSPITAL NORT	HERN INDIANA		215 W 4 ⁻ MISHAW	DDRESS, CITY, STATE, ZIP CODE TH ST STE 200 VAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
S1022	for the first 5 min accepted standard 410 IAC 15-1.5-7 (nutes, although it was the d. (d)(2)(B)					
	that include the foll (2) Ensure the mo all areas where dry are stored and why not limited to, the foll (B) Appropriate sto Based on observation and interview, the the medication or nursing units had monitoring to ensure efficacy of the monitoring to ensure the following stores. Findings includes	d and implemented flowing: Inthly inspection of ugs and biologicals ich address, but are following: Drage conditions. Action, document review, e facility failed to ensure refrigerators on the 2 daily temperature sure the quality and redications were d:	S10)22	KINDRED HOSPITAI NORTHERN INDIAN Mishawaka, Indiana Hospital License #011-002 Facility #002605 INDIANA STATE DEPART OF HEALTH STATEMENT OF DEFICIEI AND PLAN OF CORREC August 2011 S1022: Completion Date Correction of Deficiency July 30, 2011	A 2605-1 MENT NCIES TION	08/30/2011
	beginning at 2:30 accompanied by A8, the logs for t	observed lacking some e documentation.			Daily temperature monitoring not consistent on a daily basis the temperature of the medic refrigerators. Review Completed July 30, 2011 Refrigerator Temperature Ch Sheet and Medication Storage	s for ation	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		152018	B. WIN			07/20/2	011
		1	P		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	8			4TH ST STE 200		
KINDRF	D HOSPITAL NORT	HERN INDIANA		1	WAKA, IN46544		
							775
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG	•			IAG	Area Inspection Sheet were		DATE
	1	t, beginning at 3:15 PM			revised and initiated by the		
		accompanied by staff			pharmacy staff. This include	d	
		A8, the logs for the			action codes for follow-up.		
	medication refrig	gerator were observed					
	lacking some da	ily temperature			<u>Changes</u>		
	documentation.				Completed July 30, 2011		
					➤ The pharmacy staff was	J = 11	
	3. At 8:45 AM	on 07/20/11, staff member			instructed on the logging of on temperature checks for the	aaliy	
		refrigerator temperature			medication refrigerators.		
	1 -	for the last 6 months.			➤ The pharmacy staff was		
	monitoring logs	for the last o months.			instructed on the monthly		
	4 D	. 1 C			medication storage area		
	1	e logs for the medication			inspection.		
	1 -	ne Med/Surg unit					
	evidenced the fo	llowing:			Corrective Action/Monitoring July 21, 2011 Ongoing	<u>1g</u>	
					The Medical Surgical and Hi	ah	
	A. No checks for	or 16 out of 31 days in			Observation Refrigerators w		
	January 2011.				checked daily with 100%	0.0	
	B. No checks for	or 11 out of 28 days in			compliance for July 21-Augu	st 31	
	February 2011.	J			(Example 7).		
	1	or 1 out of 31 days in			August 30, 2011 Ongoing		
	March 2011.	ir i out or 51 days in			The medication storage area		
		on 5 out of 20 days in			inspection was completed in occurs monthly):	(triis	
		or 5 out of 30 days in			a) Medical/Surgical Unit		
	April 2011.				b) High Observation Unit		
		r 6 out of 31 days in May			c) Radiology Department		
	2011.				d) Dialysis Unit		
	F. No checks fo	r 3 out of 30 days in June			All areas met criteria (Examp	ole	
	2011.				8).		
					July 27, 2011 Ongoing		
	5. Review of the	e logs for the medication			The Director of Pharmacy is responsible to assure that th	e l	
	1	ne High Observation unit			temperature checks occur da		
	evidenced the fo	•			and the medication storage a	•	
					inspection occurs monthly.		
	A No shades for	or 4 out of 21 days in					
		or 4 out of 31 days in			Responsible Person(s)		
	January 2011.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/20/2011			
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		II PRE TA	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	SHOULD BE COM		
	February 2011. C. No checks for March 2011. D. No checks for April 2011. E. No checks for May 2011. F. No checks for June 2011. 6. At 12:50 PM member A8 indicated a daily check was no policy out the responsible stability (e.g., reffrom light) are stability (e.g., reffrom light) are stability continued storage area will pharmacy person inspection log is record." Staff methe monthly pharmacy pharmacy person inspection log is record." Staff methe monthly pharmacy person inspection log is record."	n 07/20/11, the member A5, provided y titled "Medication tated on page 1, "Drugs storage conditions for frigeration or protection ored as directed." The on page 2, "Medication			Kwanta NaThalang, PharmD Director, Pharmacy Jane Mason, Chief Clinical C			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						07/20/2011		
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	BROWNERS N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG				TAG			DATE	
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows:							
	(3) Defibrillators shat least in accorda manufacturers recidischarge log with shall be maintaine	nce with ommendations and a initialed entries						
	Based on observa	ation, document review,	S1	168	KINDRED HOSPITAL		09/01/2011	
	and interview, the	e facility failed to ensure			NORTHERN INDIAN			
	the defibrillators	on the units were			Mishawaka, Indiana Hospital License #011-00			
		ding to manufacturer's			Facility #002605	2005-1		
	recommendations	-			INDIANA STATE DEPART	MENT		
		3.			OF HEALTH			
	Findings included	d:			STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011 S1168: Completion Date Correction of Deficiency Complete August 15, 2011 The defibrillators were not maintained according to the manufacturer's recommendations of Phillips Heart Start once per shift. Review and Changes Completed August 15, 2011 The Code Blue Policy and Procedure was reviewed and updated to indicate changes of: a) Defibrillator to be checked every shift. b) Staff responsible for checking defibrillator. c) If department closed, defibrillator checks will occur when the department re-opens. The Emergency Equipment			
	beginning at 2:30 accompanied by A8, the logs for t defibrillator on the	or of the Med/Surg unit, OPM on 07/19/11 and staff members A7 and he Philips HeartStart XL he crash cart evidenced f daily checks of the						
	on 07/19/11 and a members A7 and Philips HeartStar crash cart eviden- daily checks of the	A8, the logs for the tXL defibrillator on the ced documentation of						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M				(X3) DATE SURVEY	
				LDING	00	COMPLETED		
	152018		B. WING			07/20/2011		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
				215 W 4TH ST STE 200				
KINDREI	O HOSPITAL NORT	HERN INDIANA		MISHAWAKA, IN46544				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re (COMPLETION	
TAG				TAG	DEFICIENCY)	DATE		
	A7 provided the June and July 2011 logs				checklist form was updated t			
	for the facility's t	three defibrillators. The			current with the Code Blue P / Procedure (Attachment 11)	· ·		
	logs evidenced documentation of daily checks and this was confirmed by staff member A7.				August 15, 2011			
					Instructed Charge Nurse and ACLS on responsibility,			
					frequency, and documentation			
	4. Review of the facility's policy titled,				Emergency Equipment Chec	klist.		
		ie Resuscitation", dated January			Corrective Action/Meniterin			
	2010, stated on page 2 under Daily				Corrective Action/Monitoring September 1, 2011 Ongoing			
		· ·			The revised Emergency	'		
	Maintenance of Code Carts, "F. Test defibrillator per manufacturer's guidelines."				Equipment checklist will indic	cate		
					defibrillator checks and			
					documentation once per shif	t		
					(once every 12 hour shift).	20)		
		e manufacturer's ne HeartStart XL			The Chief Clinical Officer (Co will monitor compliance	⁵⁰⁾		
	-				concurrently and counsel sta	ff		
	defibrillator indicated under "Operational Checks", "Perform a Shift/Systems Check every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use." The guidelines listed exactly what to do to perform the Shift/Systems Check which				members appropriately.			
					Responsible Person(s)			
						\cc:		
					Jane Mason, Chief Clinical C	micer		
	included running the strip to verify all of the systems.							
	the systems.							
	6. At 9:00 AM on 07/20/11, staff member							
		,						
		e defibrillator checks						
	were not perform	•						
	recommended by	the manufacturer.						